LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

200 W. Washington, Suite 301
Indianapolis, IN 46204
(317) 233-0696
http://www.in.gov/legislative

FISCAL IMPACT STATEMENT

LS 7471
BILL NUMBER: HB 1441

NOTE PREPARED: Feb 24, 2005
BILL AMENDED: Feb 22, 2005

SUBJECT: Medicaid Prescription Drug Coverage.

FIRST AUTHOR: Rep. Brown T
FIRST SPONSOR:

BILL STATUS: CR Adopted - 1st House

FUNDS AFFECTED: X GENERAL
DEDICATED
X FEDERAL

IMPACT: State

Summary of Legislation: (Amended) This bill allows the Office of Medicaid Policy and Planning to provide a prescription drug benefit in the Medicaid Risk Based Managed Care Program. The bill allows a managed care provider contract or provider agreement to include a prescription drug program.

Effective Date: July 1, 2005.

Explanation of State Expenditures: (Revised) *Summary:* This bill would prohibit risk-based managed care (RBMC) providers from requiring prior authorization for mental health-related drugs if a prescription drug benefit is included in the managed care capitated program operated by the Office of Medicaid Policy and Planning (OMPP) in the Medicaid and CHIP programs. The fiscal impact of this provision is unknown at this time. (This information will be updated when it becomes available.)

The bill would allow Medicaid to exclude all prescription drugs in the covered services for RBMC providers and to provide the prescription drug benefit under the fee-for-service claims processing system. If OMPP decided to pursue this option, actuarial estimates indicate the annual cost of the provision could be $14.8 M for FY 2006 (representing $5.6 M in state funds) and $17.3 M for FY 2007 (representing $6.5 M in state funds).

Additional Claims Processing: The Office does not currently process drug claims for risk-based managed care clients in the fee-for-service claims processing system. If the Office decided to discontinue the RBMC client drug claims within the contracts of the managed care organizations (MCOs), it would increase the number of claims that would be processed and paid by the contractor that processes the fee-for-service claims. OMPP

reports that under the current contract, the additional volume of claims processing would cost $167,400 each year at a minimum. However, the contract processing fees are based on anticipated volume, and OMPP reports it is possible the contractor would not agree to this increase in claims without increasing their processing thresholds and the rate. A contract amendment could result in the claims processing cost increasing by approximately $1.044 M in FY 2006, representing an increase in spending of $522,000 in state General Funds. These estimates are based on available shadow drug claims data for Medicaid MCOs, which is incomplete for the 294,149 individuals enrolled in risk-based managed care during FY 2004. Consequently, the estimates are probably conservative. Medicaid administrative expenses are matched at 50% by the federal government.

Renegotiating MCO Contracts: If the prescription drug component of the MCO contracts were eliminated, it would require at a minimum that the capitation amounts paid per member per month would have to be recalculated and the contracts amended. If the MCOs would not agree to such a significant change in the terms of their participation, it is possible that the managed care contracts would need to be reprocured; a process that takes about a year to complete.

MCO Management of Drug Expenditures: There are two components to the cost of pharmaceuticals purchased: what the purchaser actually pays for the various products (a negotiated price); and the actual mix of products purchased (prescribing management practices).

Negotiated prices: Medicaid generally pays the lower of several defined costing options, one of which is the Average Wholesale Price (AWP) less 13.5% for brand-name drugs and AWP less 20% for generic drugs, plus a $4.90 dispensing fee. Without access to the MCOs' actual cost of drug products, it would be difficult to determine whether the Medicaid cost for drugs would be higher or lower than what the MCOs currently pay.

Prescribing management: While the MCOs' costs for drugs are unknown, it is clear that MCOs have other effective tools they use to manage the mix of products they buy (or don't buy), and consequently, the total dollars spent on pharmaceuticals. MCOs use preferred drug lists, as does the Medicaid program. However, MCOs also have strong relationships with their primary care providers (PMPs) and encourage the PMPs to write scripts for preferred drugs. The MCOs can also offer bonuses based on prescribing practices of the PMPs. The MCOs also have strong quality and utilization management controls that help them manage pharmacy costs.

OMPP reports that the MCOs' total pharmacy expenditures on a per member per month basis are consistently and significantly lower than the similar population in the more loosely managed fee-for-service-based Primary Care Case Management (PCCM) program. RBMC self-reported pharmacy costs average around $20 to $25 per member per month while the PCCM claims average $35 to $40 per member per month. If the MCO pharmacy management controls are removed, costs for the 294,149 enrolled Medicaid MCO participants could potentially increase to average the PCCM experience. The Medicaid actuary has estimated the cost of "carving out the prescription drug component from the managed care contracts could be $13.8 M in the first year and $16.3 M in the second year. In additional total spending for drugs, this would represent a range of $5.1 M and $6.0 M in state General Fund dollars and $8.7 M and $10.3 M in federal funds for each year, respectively.

Medicaid is jointly funded by the state and federal governments. The state share of program expenditures is approximately 38%. Medicaid medical services are matched by the federal match rate (FMAP) in Indiana at approximately 62%. Administrative expenditures are generally matched at 50%.

Explanation of State Revenues: *Additional Drug Rebates:* Additional drug purchases in the fee-for-service

system would have offsetting drug rebate revenue associated. The actuarial estimates discussed above are net cost estimates; they include the impact of increased rebates. The federal government participates in the rebate revenue at the same matching percentage used for claims, or approximately 62%.

See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: Office of Medicaid Policy and Planning, Family and Social Services Administration.

Local Agencies Affected:

Information Sources: Kristy Bredemeier, Acting Legislative Liaison, Office of Medicaid Policy and Planning, 317-233-2127.

Fiscal Analyst: Kathy Norris, 317-234-1360.